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Workers' Memorial Day — April 28, 2005

Workers' Memorial Day, April 28, was established in 1989 as an international day of remembrance for workers who died or were injured on the job. This day also commemorates the 34th anniversary of the National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration, both of which were created by the U.S. Occupational Safety and Health Act.

On average, in the United States, nearly 11,000 workers are treated in emergency departments each day, and approximately 200 of these workers are hospitalized (*1*). An estimated 6,300 private-sector workers require time away from their jobs (*2*), 15 workers die from their injuries (*3*), and 134 die from work-related diseases (*4*). These losses account for nearly $73 billion in workers' compensation (*5*). International and national prevention practices during the preceding 3 decades have reduced these losses, but morbidity and mortality from occupational hazards are still a major social and economic burden.

This issue of *MMWR* includes reports on occupational safety and health in recognition of Workers' Memorial Day. Additional information about this day is available at http://www.ilo.org/public/english/protection/safework and http://www.aflcio.org/issuespolitics/toolkit/fliers.cfm. Information on workplace safety and health is available at http://www.cdc.gov/niosh/homepage.html or by telephone, 800-356-4674.

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Silicosis Mortality, Prevention, and Control — United States, 1968–2002

Silicosis is a preventable occupational lung disease caused by inhaling dust containing crystalline silica (*1*); no effective treatment for silicosis is available. Deaths from inhalation of silica-containing dust can occur after a few months' exposure (*1*). Crystalline silica exposure and silicosis have been associated with work in mining, quarrying, tunneling, sandblasting, masonry, foundry work, glass manufacture, ceramic and pottery production, cement and concrete production, and work with certain materials in dental laboratories. To describe patterns of silicosis mortality in the United States, CDC analyzed data from the National Institute for Occupational Safety and Health (NIOSH) National Occupational Respiratory Mortality System (NORMS) for 1968–2002. This report summarizes the results of that analysis, which indicated a decline in silicosis mortality during 1968–2002 and suggested that progress has been made in reducing the incidence of silicosis in the United States. However, silicosis deaths and new cases still occur, even in young workers. Because no effective treatment for silicosis is available, effective control of exposure to crystalline silica in the workplace is crucial.

NORMS contains national mortality data obtained annually since 1968 from the National Center for Health Statistics (NCHS) for asthma, chronic obstructive pulmonary disease, silicosis, pneumoconiosis, tuberculosis, and other respiratory diseases and conditions (*2*). For this report, silicosis deaths were identified during 1968–2002, the most recent years for which complete data were available, and include any death

INSIDE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

certificates for which an *International Classification of Diseases* (ICD) code* for silicosis was listed as either the underlying or contributing cause of death. Death rates (per million persons aged ≥15 years) were age-adjusted to the 2000 U.S. standard population. The age-adjusted mortality rates were mapped by county by using geographic information system software. Codes for usual occupation or industry were available for 1985–1999 from 26 states†. The proportionate mortality ratio (PMR§) for silicosis was calculated by occupation and industry. For this analysis, PMR was adjusted by age, sex, and race, and 95% confidence intervals (CIs) were calculated by using Poisson regression analysis.

During 1968–2002, of approximately 74 million death certificates, silicosis was recorded as the underlying or contributing cause of death on 16,305; a total of 15,944 (98%) deaths occurred in males. From 1968 to 2002, the number of silicosis deaths decreased from 1,157 (8.91 per million persons aged ≥15 years) to 148 (0.66) (Figure 1), corresponding to a 93% decline in the overall mortality rate. The racial distribution of persons who died from silicosis was approximately 88% (14,310 decedents) white, 12% (1,925) black, and <1% (70) other race. Since 1995, on average, 30 deaths per year have been recorded among persons aged 15–64 years.

During 1968–2002, the age-adjusted silicosis mortality rate was elevated in several counties in western states (Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Washington), eastern states (Georgia, Kentucky, New York, North Carolina, Maine, Ohio, Pennsylvania, Tennessee, Vermont, Virginia, and West Virginia), and central states (Illinois, Kansas, Michigan, Minnesota, Missouri, Oklahoma, South Dakota, Vermont, and Wisconsin). San Juan County, Colorado, had the highest age-adjusted mortality rate (524 per million persons aged ≥15 years) (Figure 2).

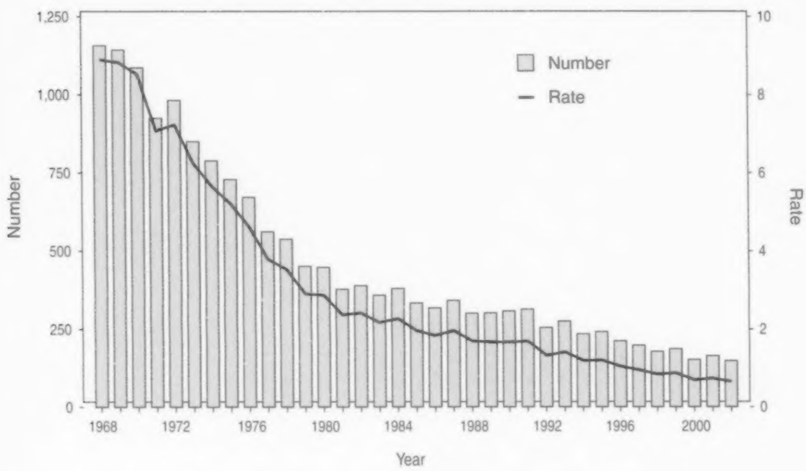
For usual industry and occupation codes, a total of 1,400 silicosis deaths were reported in the 26 states for one or more selected years during 1985–1999. Metal mining had the highest PMR (39.2; CI = 32.9–46.8) among industries (Table). Among occupations, miscellaneous metal and plastic-

* ICD-8 code 515 (1968–1978), ICD-9 code 502 (1979–1998), and ICD-10 code J62 (1999–2002) (*3*).

† Alaska, Colorado, Georgia, Hawaii, Idaho, Indiana, Kansas, Kentucky, Maine, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Washington, West Virginia, and Wisconsin.

§ Defined as the observed number of deaths from silicosis in a specified occupation or industry divided by the expected number of silicosis deaths. The expected number of deaths was calculated by using the total number of deaths in the Bureau of Census Industry Code or Census Occupation Code of interest multiplied by a proportion defined as the number of cause-specific deaths for the condition of interest in all industries/occupations, divided by the total number of deaths in all industries/occupations.

FIGURE 1. Number of silicosis deaths and age-adjusted mortality rate*, by year — National Occupational Respiratory Mortality System, United States, 1968–2002



* Per million persons aged ≥15 years.

processing machine operator had the highest PMR (90.1; CI = 51.5–146.3).

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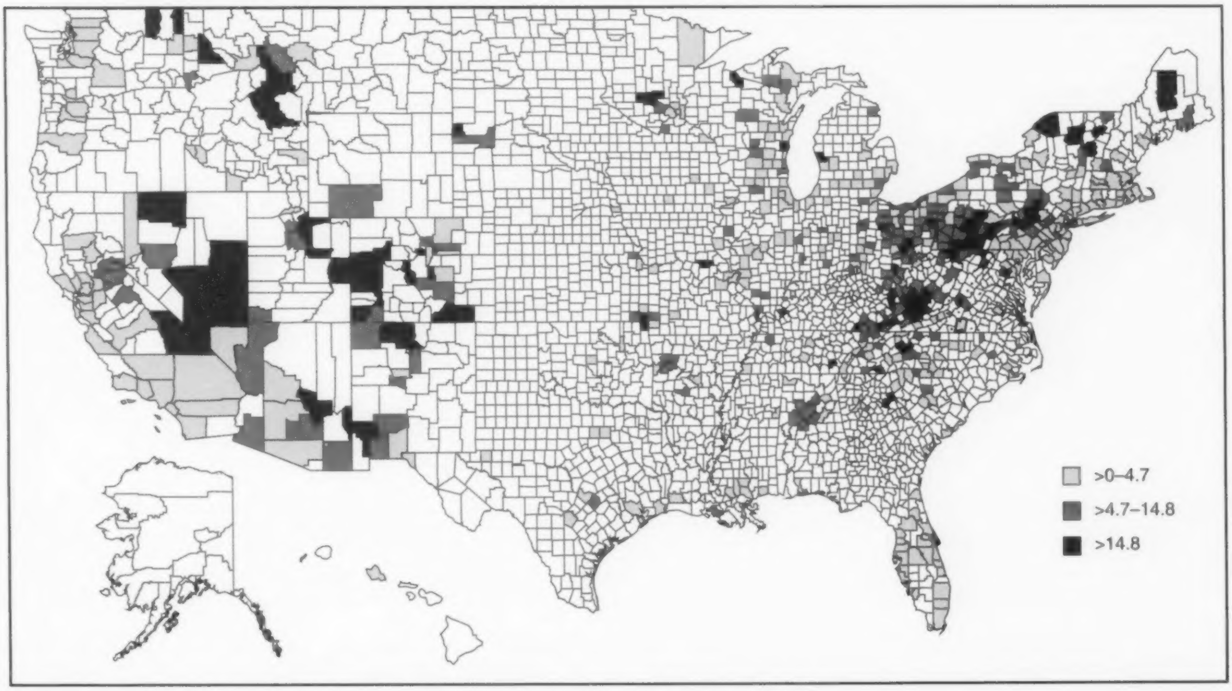
Editorial Note: The greatest death toll from silicosis in the United States occurred with excavation of Hawk's Nest Tunnel, critical to the construction of a hydroelectric plant in West Virginia during 1930–1931. Approximately 5,000 workers bored through Gauley Mountain to create the tunnel; an estimated 2,500 worked inside. A subsequent study determined that silicosis claimed the lives of at least 764 workers at Hawk's Nest Tunnel (*4*). By the end of 1937, a total of 46 states had passed laws relevant to workers with silicosis.

FIGURE 2. Geographic distribution of age-adjusted silicosis mortality rates*, by county — National Occupational Respiratory Mortality System, United States, 1968–2002



* Per million persons aged ≥15 years. Rates were not calculated for counties with fewer than five deaths.

TABLE. Top 10 significantly elevated proportionate mortality ratios (PMRs*) for silicosis, by industry and occupation code† — National Occupational Respiratory Mortality System, 26 states§, 1985–1999

Code	Description	No. of deaths¶	PMR	(95% CI**)
Industry				
040	Metal mining	128	39.2	(32.9–46.8)
262	Miscellaneous nonmetallic mineral and stone products	79	32.2	(25.7–40.4)
261	Pottery and related products	30	31.3	(21.1–44.6)
050	Nonmetallic mining and quarrying, except fuel	80	30.4	24.3–38.1)
271	Iron and steel foundries	84	20.2	(16.3–25.2)
252	Structural clay products	30	16.9	(11.4–24.2)
041	Coal mining	101	5.6	(4.6–6.9)
300	Miscellaneous fabricated metal products	27	4.8	(3.1–7.0)
682	Miscellaneous retail stores	14	4.0	(2.2–6.7)
270	Blast furnaces, steelworks, rolling, and finishing mills	91	3.4	(2.8–4.2)
Occupation				
725	Miscellaneous metal and plastic-processing machine operators	16	90.1	(51.5–146.3)
675	Hand molders and shapers, except jewelers	27	40.8	(26.8–59.4)
787	Hand molding, casting, and forming occupations	12	32.3	(16.6–56.3)
768	Crushing and grinding machine operators	29	30.8	(20.7–44.2)
719	Molding and casting machine operators	43	19.3	(14.0–26.0)
046	Mining engineers	5	16.4	(5.3–38.2)
616	Mining machine operators	208	12.1	(10.6–13.9)
617	Mining occupations, not elsewhere classified	12	11.2	(5.8–9.6)
613	Supervisors, extractive occupations	9	10.9	(5.0–20.6)
599	Construction trades, not elsewhere classified	16	7.5	(4.3–12.1)

* Defined as the observed number of deaths from silicosis in a specified occupation or industry divided by the expected number of silicosis deaths. The expected number of deaths was calculated by using the total number of deaths in the Bureau of Census Industry Code or Census Occupation Code of interest multiplied by a proportion defined as the number of cause-specific deaths for the condition of interest in all industries/occupations, divided by the total number of deaths in all industries/occupations.
† 1990 U.S. Census codes.
§ Alaska, Colorado, Georgia, Hawaii, Idaho, Indiana, Kansas, Kentucky, Maine, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Washington, West Virginia, and Wisconsin.
¶ Among persons aged ≥15 years.
** Confidence interval.

The findings in this report indicate a decline in silicosis mortality during 1968–2002. Two main factors are likely responsible for this trend. First, many of the deaths in the early part of the study period occurred among persons whose main exposure to crystalline silica dust probably occurred before introduction of national compliance standards for silica dust exposure (the Mine Safety and Health Administration [MSHA] and the Occupational Safety and Health Administration use permissible exposure limits [PELs] based on the American Conference of Governmental Industrial Hygienists threshold limit value). These limits began to be applied in the early 1970s and included indirect control through regulation of mixed mine dust in underground coal mines by using the MSHA formula¶ (*5*). These regulatory limits, coupled with other recommendations such as that by NIOSH in 1974 (i.e., recommended exposure limit [REL] to respirable crystalline silica shall not exceed 0.05 mg/m^3) (*6*), likely has led to reduced silica dust exposures since the 1970s. Ancillary preventive measures (e.g., respiratory protection, posting warning signs, and recordkeeping or reporting occupational illnesses) might also have reduced personal exposures. The second major factor relates to declining employment in heavy industries (e.g., mining industry from 989,400 employees in 1980 to 512,200 in 2002), where silica exposures were prevalent.

Despite the reductions in mortality associated with silicosis, silica overexposure remains widespread, indicating a need for hazard surveillance and developing work place–specific interventions. An estimated 121,100 workers were exposed to equal to or greater than the NIOSH REL in 1993 (*7*). The industries with the largest number of workers exposed include research and testing services (46,200 workers), masonry (20,400), heavy construction (12,200 [excluding highway construction]), and iron and steel foundries (8,600). Industries with fewer workers include painting and paper hanging (5,100), structural clay products (2,100), metal services (1,300), and cut stone (700) (*7*). By industry, metal mining had the highest PMR for 1985–1999. At least 12% of metal mining exposures exceeded the MSHA PEL during 1990–1999 (*8*). Findings from the Sentinel Event Notification Systems for Occupational Risks indicated that 58% of reported cases of silicosis from Michigan, New Jersey, and Ohio occurred in workers in primary metal industries (*9*).

¶ (10 mg/m^3) / (% quartz) and direct control of crystalline silica as respirable quartz in metal/non-metal mining using the formulas: (10 mg/m^3) / (% quartz + 2) for general industry or (250 mppcf) / (% quartz + 5) for the construction industry.

Additional industries with elevated PMRs involved miscellaneous nonmetallic and stone products and pottery and related products. The pottery industry deals with silica-containing clay, which is the raw material for manufacturing crockery, pottery, and flint.

The geographic patterns of silicosis offer some guidance for intervention. By county, the greatest age-adjusted mortality rates were clustered in western states, northeastern states, and north Atlantic states. The mortality rates in counties in these states were often associated with mining or construction industries. For example, the high age-adjusted death rate in Lawrence County, South Dakota (38.3 per million persons aged $\geq$15 years), might be associated with gold mining in that area. A study of 3,328 gold miners exposed to silica in South Dakota reported an increased risk for silicosis (*9*).

The findings in this report are subject to at least five limitations. First, accuracy of the coding of usual industry and occupation on death certificates was not verifiable because individual work histories are not listed on death certificates. Second, codes for usual industry and occupation were available only for the period 1985–1999 for 26 states; thus, these data might not be nationally representative. Twenty-four states do not provide decedents' employment data to NCHS. Third, the state of residence at death is not always the state in which decedents' exposures occurred. Fourth, no exposure information is listed on death certificates. Therefore, no silica exposure-response relationship was evaluated. Finally, physicians might have misclassified or underreported silicosis deaths.

Despite these limitations, NORMS can provide useful information on silicosis by location, industry, and occupation, suggesting ways to target preventive intervention. The decreased silicosis mortality trends suggest that considerable progress has been made toward elimination of silicosis since 1968. However, silicosis deaths and new cases are still occurring, even in young workers in the United States. Because no effective treatment for silicosis is available, primary prevention (i.e., engineering or other control of exposure) should be maintained or improved to reduce worker morbidity and mortality.

Acknowledgments

The findings in this report are based, in part, on contributions by JM Wood, MS, G Syamlal, MPH, Div of Respiratory Disease Studies, National Institute for Occupational Safety and Health, CDC.

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Update: Hydrogen Cyanamide–Related Illnesses — Italy, 2002–2004

Hydrogen cyanamide* is used in agriculture as a plant growth regulator and is applied to many deciduous plants to stimulate uniform budbreak after dormancy, resulting in uniform flowering and maturity. Hydrogen cyanamide is highly toxic, and adverse health effects from contact include severe irritation and ulceration of the eyes, skin, and respiratory tract (*1,2*). The substance also inhibits aldehyde dehydrogenase and can produce acetaldehyde syndrome (e.g., vomiting, parasympathetic hyperactivity, dyspnea, hypotension, and confusion) when exposure coincides with alcohol use. After Dormex® (Degussa AG, Trostberg, Germany), a pesticide product containing hydrogen cyanamide (49% by weight), was introduced in Italy in 2000, a total of 23 cases of acute illness associated with exposure to this chemical were identified in early 2001 (*3*). This led to a temporary suspension of sales and usage of Dormex on February 23, 2002, and strengthening of protective measures, as specified on the pesticide label when sales were resumed on June 20, 2003. This report describes 28 additional cases of hydrogen cyanamide–related illness that occurred during 2002–2004, 14 of which occurred after sales resumed. These illnesses suggest that the preventive measures

*Chemical Abstracts Service no. 420-04-2.

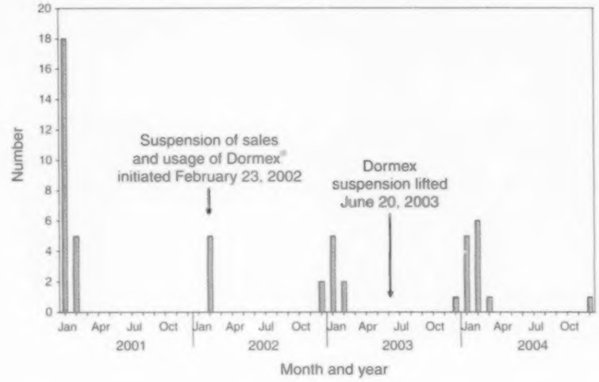
adopted in Italy in 2003 to protect workers using hydrogen cyanamide are inadequate. Workers exposed to hydrogen cyanamide should be provided adequate information, training, personal protective equipment (PPE), and engineering controls.

Public Health Surveillance

In 2000, a pilot pesticide-poisoning surveillance program was undertaken by the Italian National Institute of Health (INIH) in collaboration with the Milan Poison Control Center (MPCC) and the Ragusa Local Health Unit (RLHU). This program has identified symptomatic cases involving Dormex exposure during 2001–2004. A previous report described cases from 2001 (*3*); cases identified during 2002–2004 are described in this report. Cases were classified as definite, probable, possible, or suspicious on the basis of clinical interpretation of signs or symptoms reported by a physician or patient[†] and evidence of Dormex exposure (*4*). Illness severity[§] was also categorized for all cases (*5*).

A total of 28 hydrogen cyanamide–related illnesses were identified during 2002–2004. All cases were identified by MPCC, and three cases were detected by RLHU. Five cases were identified before the Dormex suspension was enacted, nine cases were identified during the suspension (whether workers used chemical purchased before the suspension or if an illegal purchase had occurred during the suspension is unknown), and 14 cases were identified after the suspension was lifted (Figure). All of the cases occurred in males; median age was 41 years (range: 25–65 years). All cases occurred from late December through early March of each year (Figure), which is the only period when Dormex is used in Italy. A total of 25 of the 28 cases occurred in persons who were exposed during application of Dormex. Another person was exposed while handling a Dormex packet found in the field and whose contents inadvertently spilled on the person, and one person was exposed from unintentional ingestion after the product was poured from its original container into a drinking bottle. For one case, no information on activity at time of exposure was available. Among the 25 cases involving exposure during application, 20 (80%) occurred in persons who were exposed while using a backpack sprayer, two (8%) while sitting in an open tractor cab, and one (4%) while crossing a treated field;

FIGURE. Number of cases of hydrogen cyanamide–related illness, by month and year — Italy, 2001–2004



information was not available for two cases (8%). Among the 21 cases with information available on use of PPE, only one involved a person who wore complete PPE (e.g., air-purifying respirator, goggles/face shield, chemical-resistant gloves, protective suit, and footwear). The majority (14 [66%]) of these persons used incomplete PPE (e.g., five reported using an air-purifying respirator but no other PPE), and six used no PPE. No deaths and no illnesses of high severity were identified. Eleven (40%) cases were classified as of moderate severity and 17 as low severity. Among the 14 cases that occurred after the Dormex suspension was lifted, seven (50%) were of moderate severity. The latency between exposure and onset of adverse effects ranged from 30 minutes to 30 hours. In 13 cases, signs or symptoms appeared immediately after alcohol consumption. Skin-related signs and symptoms occurred in most cases (Table).

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Editorial Note: The findings in this report indicate that, despite reports of hydrogen cyanamide–related cases in 2001 and strengthening of protective measures (i.e., requirements for more protective PPE and prohibition of some application methods) in Italy in 2003, illnesses related to hydrogen cyanamide continue to be identified. A comparison of the findings in Italy with case data in the United States might be useful. The United States has several surveillance systems to track pesticide poisoning, including the Sentinel Event Notification System for Occupational Risks (SENSOR)-Pesticides program, the California Department of Pesticide

† The entire case definition is available at http://www.cdc.gov/niosh/topics/pesticides/pdfs/casedef2003_revAPR2005.pdf.

§ A low severity illness consists of minimally bothersome health effects that generally resolve rapidly. A moderate severity illness or injury consists of non-life-threatening health effects that are more pronounced, prolonged, or of a systemic nature, compared with a low severity illness. A high severity illness or injury consists of life-threatening health effects or those that result in substantial residual disability or disfigurement.

TABLE. Number* and percentage of workers with hydrogen cyanamide–related illness, by selected characteristics — Italy, 2002–2004

Characteristic	No.	(%)
Year of exposure		
2002	8	(29)
2003	7	(25)
2004	13	(46)
Case-definition category		
Definite	18	(64)
Probable	5	(18)
Possible	1	(4)
Suspicious	4	(14)
Region		
Sicily	12	(43)
Apulia	10	(36)
Calabria	6	(21)
Dermatologic signs and symptoms	21	(75)
Edema	2	(7)
Erythema	12	(43)
Dermatitis	10	(36)
Burn	2	(7)
Neurologic signs and symptoms	11	(39)
Dizziness	4	(14)
Agitation/Confusion	2	(7)
Delirium	2	(7)
Tremors	1	(4)
Weakness	1	(4)
Paresthesias	1	(4)
Sweating	1	(4)
Headache	1	(4)
Gastrointestinal signs and symptoms	5	(18)
Nausea/Vomiting	3	(11)
Heartburn	1	(4)
Oral cavity erythema	1	(4)
Throat irritation	1	(4)
Cardiovascular signs and symptoms	4	(14)
Tachycardia/Palpitations	3	(11)
Hypertension	1	(4)
Respiratory signs and symptoms	4	(14)
Dyspnea	3	(11)
Bronchospasm	1	(4)
Ocular signs and symptoms	4	(14)
Hyperemia/Conjunctivitis	3	(11)
Miosis	1	(4)
Other	1	(4)
Acetaldehyde syndrome	1	(4)

* N = 28.

Regulation (CDPR) system, and the Toxic Exposure Surveillance System (*4*). During 2000–2004, only one U.S. case of hydrogen cyanamide–related illness was identified. This case was identified by CDPR and involved a worker in California in January 2004 who developed a rash on his wrists, arms, and knees within 24 hours of mixing and loading hydrogen cyanamide. Overall amounts of hydrogen cyanamide used in California are higher than in Italy. In 2001, an estimated 248,000 pounds of hydrogen cyanamide were used in California, compared with 80,000 pounds sold in Italy (*6*; Degussa AG, unpublished data, 2005), where it is primarily used on grapes.

The number of illnesses identified since Dormex was reintroduced in Italy is lower than the number of illnesses observed in 2001 (14 from June 2003–December 2004 versus 23 in January–February 2001). Nevertheless, the number suggests that current preventive measures in Italy are not adequate. In particular, many workers did not use engineering controls or follow PPE requirements. Although the Italian pesticide label provides detailed information on PPE, the information on engineering controls is vague, with no mention of requiring closed systems. Efforts are needed to ensure the use of engineering controls (i.e., mixing, loading, and transferring of the chemical only in a closed system), which precludes the use of backpack sprayers. Of the 13 workers who became ill after the Dormex suspension was lifted, nine used backpack sprayers. Efforts are also needed to ensure appropriate use of PPE, which might require improved clarity of PPE information on the pesticide label and enhanced enforcement of PPE requirements. In addition, because many workers have onset of illness immediately after alcohol consumption, including eight workers after the Dormex suspension was lifted, the label language that warns against alcohol consumption might need to be strengthened. Because all of the cases were identified in three Italian regions (Table), these regions should be targeted with appropriate public health interventions. These interventions include educating growers and agricultural workers about hydrogen cyanamide–related health effects, ensuring that all exposed workers are provided with and trained to use appropriate PPE and promoting the adoption of engineering controls.

As in other European countries, each pesticide product in Italy is assigned an overall risk category based on the toxicologic properties of the active ingredients in the product and their concentrations. When sales of Dormex were resumed in Italy in 2003, Italian authorities assigned a risk category of "toxic" to the product. Before Dormex sales were suspended in Italy in 2002, the product was assigned a risk category of "harmful," which is the equivalent of Environmental Protection Agency (EPA) toxicity category II[¶]. EPA classifies Dormex into the highest toxicity category (toxicity category I) because of its corrosive effects on the skin and eyes (*7*). EPA toxicity category I is equivalent to Italy's "toxic" category. In addition to the requirements imposed on all toxicity category I pesticides, EPA imposed additional restrictions to protect workers handling hydrogen cyanamide (e.g., consumption of alcoholic beverages is prohibited before, during, and 24 hours

[¶] EPA classifies all pesticide products into one of four toxicity categories on the basis of established criteria (40 CFR 156). Pesticides with the greatest toxicity are in category I, and those with the least are in category IV.

after handling this product). Hydrogen cyanamide is currently under regulatory review by European Union authorities (*8*).

The findings in this report are subject to at least two limitations. First, the reported cases likely provide a minimum estimate of the true magnitude of hydrogen cyanamide–related illnesses in Italy. Although several poison control centers operate in Italy, only MPCC provided data for this report. However, MPCC is the most frequently consulted poison control center in Italy. Second, although all of these cases involved illnesses that were consistent with the case-definition criteria, the possibility of false positives cannot be excluded. Given the nonspecificity of the clinical findings of hydrogen cyanamide poisoning and the lack of a "gold standard" diagnostic test, some illnesses temporally related to hydrogen cyanamide exposure might be coincidental and not exposure related.

The findings in this report demonstrate the value of using surveillance data to evaluate the effectiveness of an intervention. In addition, the findings illustrate the international nature of pesticide-related concerns and the usefulness of coordination of policies and requirements to protect worker health and safety.

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Progress Toward Interruption of Wild Poliovirus Transmission — Worldwide, January 2004–March 2005

In 1988, the World Health Assembly of the World Health Organization (WHO) resolved to eradicate poliomyelitis globally (*1*). Since then, substantial worldwide progress has been made toward that goal; the number of countries where polio is endemic declined from 125 in 1988 to six by the end of 2003. Further progress in 2004 toward interruption of transmission has continued in the three Asian countries where polio is endemic (Afghanistan, India, and Pakistan) (*2,3*). However, in 2003, two countries in Africa experienced a resurgence of polio cases; the resurgence continued to spread in 2004 from the Nigeria-Niger endemic reservoir to involve a total of 14 countries that had not reported polio ≥1 year. Local transmission of wild poliovirus (WPV) has been reestablished in six of these 14 countries, including Sudan, where a major outbreak occurred. This report describes global efforts to eradicate polio during January 2004–March 2005 and outlines remaining challenges to interrupting transmission in countries where polio remains endemic or transmission has been reestablished.

Routine Vaccination Activities

Throughout the world, routine vaccination coverage among infants with 3 doses of oral poliovirus vaccine (OPV3) was estimated at 78% in 2003, the most recent year with fully reported data. Estimated coverage varied substantially among WHO regions*, from 61% in the African Region to 91% in the European Region, with a wide range in estimates for individual countries. In countries where polio is endemic, estimated OPV3 coverage in 2003 was 39% in Nigeria, 51% in Niger, 54% in Afghanistan, 69% in Pakistan, 70% in India, and 98% in Egypt (*4*).

Supplementary Immunization Activities (SIAs)†

To raise population immunity to the level required to interrupt WPV transmission, SIAs to vaccinate children aged

* WHO has six designated regions: African (46 member states and areas), American (35), Eastern Mediterranean (22), European (52), Southeast Asian (11), and Western Pacific (27).

† Scheduled SIAs consist of 1) national immunization days (NIDs), which are nationwide mass campaigns during a limited number of days in which doses of OPV are administered to children (usually aged <5 years) regardless of previous vaccination history, with an interval of 4–6 weeks between doses, and 2) subnational immunization days (SNIDs), which are campaigns similar to NIDs but confined to certain parts of the country. Mopping-up SIAs are more intensified campaigns conducted in areas of poliovirus transmission.

<5 years with additional OPV doses (i.e., regardless of routine vaccination history) were conducted in 2004 in 45 countries (six countries where polio is endemic, five with reestablished transmission, seven with virus importations, and 26 polio-free countries at high risk for importation). The 45 countries conducted a total of 171 SIAs[§] by using approximately 2.4 billion doses of OPV to vaccinate approximately 372 million children.

In July 2004, polio SIAs were resumed in Kano state in northern Nigeria after their suspension for nearly 12 months because of unfounded concerns regarding vaccine safety that affected campaigns in several northern states (*2*). Since resumption in Kano state, public acceptance of OPV has increased there and in other northern Nigerian states. In response to the resurgence of polio in Africa and under the auspices of the African Union, synchronized National Immunization Days (NIDs) were conducted twice in late 2004 in 23 western and central African countries and Sudan, reaching approximately 80 million children. However, the November round of NIDs was suspended in Côte d'Ivoire because of renewed armed conflict. Synchronized NIDs were conducted in 21 countries in February and April 2005, with three additional rounds planned for later in 2005.

Acute Flaccid Paralysis (AFP) Surveillance

The quality of AFP surveillance is monitored by two key performance indicators: 1) the rate of nonpolio AFP (NPAFP) cases (i.e., those not caused by WPV), which has a target of one or more cases per 100,000 children aged <15 years; and 2) the proportion of persons with AFP with adequate stool specimens, which has a target of ≥80%[¶]. All specimens are processed in a polio laboratory accredited by WHO and annually reviewed; all WPV isolates undergo genomic sequencing in specialized reference laboratories.

The overall sensitivity of AFP surveillance, as measured by the two indicators, was maintained at or near target levels in all WHO regions in 2004 (Table); the global average NPAFP rate increased from 1.9 in 2003 to 2.3 in 2004 (ranging in 2004 from 1.1 in the European Region to 3.0 in the African Region). The proportion of persons with AFP with adequate specimens remained at 86% globally. However, when averaging global, regional, or national indicators, suboptimal performance quality indicators in smaller areas might be masked. For example, 136 (23%) of the 594 districts in India in 2004 did not meet the percentage target for adequate specimen collection**; in Nigeria, 304 (40%) of the 774 local governments did not meet the target.

The increase in NPAFP rates in regions where polio is endemic was largely the result of increased AFP reporting from three countries: India (NPAFP rate increased from 2.0 per 100,000 children aged <15 years in 2003 to 3.0 in 2004), Nigeria (6.0 to 8.2), and Pakistan (3.0 to 3.5). These rate increases followed efforts to improve the sensitivity of field AFP surveillance; in India and Pakistan, these efforts were concurrent with decreasing intensity of virus transmission. All six countries where polio is endemic and four (Burkina Faso, Côte d'Ivoire, Mali, and Sudan) of the six countries with reestablished transmission met target surveillance indicators at the national level.

Detailed analyses of genetic sequencing[††] information in 2004 revealed the persistence of surveillance quality gaps in many countries with endemic or reestablished transmission, which was confirmed by analysis of the primary indicators of surveillance quality at the subnational level. Both type 1 and type 3 WPV lineages were isolated in Sudan that genetically indicated circulation had been undetected for at least 3 years in the Chad/Sudan epidemiologic block. Similarly, genetic evidence of surveillance gaps and undetected transmission of WPV type 1 and type 3 for considerable periods was identified in Nigeria and other western African countries and to a lesser extent in Pakistan and Afghanistan. Indicators of suboptimal surveillance quality have been identified in subnational areas of these countries. Surveillance gaps in several countries were identified generally in areas affected by security problems (e.g., southern Sudan, Kandahar region of Afghanistan, and southern Punjab province in Pakistan), which permitted limited access for vaccination and surveillance activities. Despite the 2004 polio epidemic in the African Region, NPAFP rates in the majority of western African countries either did not increase or declined.

WPV Incidence

Despite a decrease in Afghanistan, India, and Pakistan from 336 reported polio cases in 2003 to 193 to 2004, the number of polio cases reported globally increased from 784 in 2003 to 1,266 in 2004. This was the result of the increase in transmission in Nigeria from 355 polio cases in 2003 to 792 reported cases in 2004 and extensive subsequent transmission in other African countries, including an outbreak in Sudan in late 2004 (*6*) that continues (Table). The Sudan outbreak (126 cases) subsequently led to virus importations into Ethiopia and Saudi Arabia.

§ 115 NIDs, 42 SNIDs, and 14 mopping-up activities.

¶ Two stool specimens collected ≥24 hours apart within 14 days of paralysis onset and received in the laboratory in acceptable condition.

** For areas with ≥100,000 children aged <15 years.

†† The genetic sequence of the complete VP1 coding region is determined by using automated dye-labeled cycle sequencing procedures described previously (*5*) and comparing the resulting sequences with a database of all recent poliovirus isolates. The comparisons are summarized through phylogenetic analysis.

TABLE. Acute flaccid paralysis (AFP) surveillance data (2004) and virus-confirmed cases of poliomyelitis (2004 and January–March 2005), by World Health Organization (WHO) region and country — worldwide*

Region/Country	No. reported AFP cases 2004	Nonpolio AFP rate† 2004	% persons with AFP with adequate specimens§ 2004	No. virus-confirmed cases 2004	No. virus-confirmed cases 2005
African	9,687	3.0	89%	944	38
Burkina Faso	155	2.5	82%	9	0
Central African Republic	121	4.5	75%	30	0
Chad	124	2.2	73%	24	0
Côte d'Ivoire	161	1.9	88%	17	0
Mali	127	2.0	82%	19	0
Niger	180	2.7	84%	25	0
Nigeria	4,813	8.2	91%	792	36
Eastern Mediterranean	6,174	2.7	89%	186	23
Afghanistan	686	4.6	91%	4	0
Egypt	768	2.8	92%	1	0
Pakistan	2,629	3.5	88%	53	4
Sudan	605	3.3	87%	126	19
South-East Asian	16,255	2.6	83%	136	13
India	13,266	3.1	82%	136	13
American	2,280	1.4	79%	—	
European	1,518	1.1	81%	—	
Western Pacific	6,511	1.6	88%	—	
Worldwide	**42,425**	**2.3**	**86%**	**1,266**	**74**

* Data as reported to WHO as of April 12, 2005. Only countries with endemic polio and countries with reestablished transmission are included. Row amounts do not add to column totals. When averaging global, regional, or national surveillance indicators, suboptimal performance-quality indicators in smaller areas might be masked.
† Per 100,000 children aged <15 years.
§ Two stool specimens collected at an interval of ≥24 hours within 14 days of paralysis onset and adequately shipped to the laboratory (except for the American Region, where adequate is one specimen collected within 14 days of onset).

In 2004, India reported its lowest number of cases ever (136), with transmission primarily limited to key districts in western Uttar Pradesh and Bihar (Figure 1). The campaign in India continued to focus on vaccinating the last remaining pockets of unvaccinated or undervaccinated children. District and subdistrict plans were revised in 2004 to better reach underserved communities in areas with populations at high risk and to vaccinate more children moving through busy transit points, such as bus or railway terminals.

In Pakistan, long periods occurred without WPV reported in either North-West Frontier (5 months) or Balochistan provinces (13 months), suggesting that WPV transmission is limited primarily to southern Punjab and Sindh provinces. However, WPV type 1 was recently isolated again in North-West Frontier and Balochistan provinces; this finding and the observed subnational surveillance gaps indicate that low-level transmission might still be widespread.

In Egypt, only one WPV type 1 confirmed case of polio was reported in 2004 (Figure 2); however, sampling of sewage indicates persistent, low-level transmission of two separate lineages of WPV type 1 across the country, particularly in Cairo/Giza (lower Egypt) and Minya and Asiut governorates (upper Egypt) (*7*). WPV type 3 has not been reported since December 2000.

During 2004, Nigeria experienced a national polio outbreak that expanded beyond the northern states, where endemic transmission has occurred uninterrupted. Nigeria accounted for 62% of the global 2004 case burden (792 of 1,266 cases). Across the African continent and Saudi Arabia, 14 previously polio-free countries had poliovirus importations during 2003–2004 that spread from the Nigeria-Niger endemic reservoir, most recently including Ethiopia. Indigenous WPV transmission (i.e., transmission of an imported virus for ≥6 months) has been reestablished in six previously polio-free countries: Burkina Faso, the Central African Republic, Chad, Côte d'Ivoire, Mali, and Sudan.

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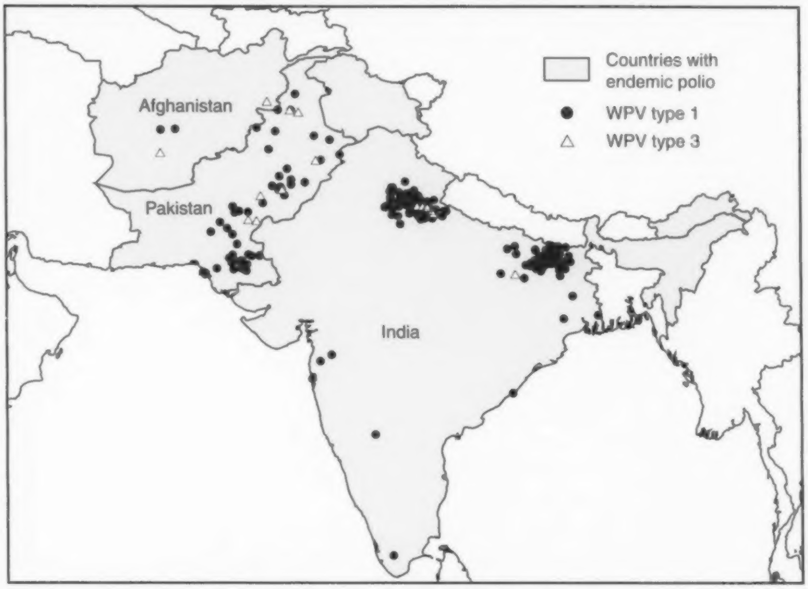
Editorial Note: Substantial progress toward polio eradication was achieved during 2004 in India, Pakistan, Afghanistan, and Egypt, where the lowest-ever levels of confirmed polio cases were reported during the second half of 2004, which is the peak season for WPV transmission. In addition, during January–March 2005, the number of cases remained low. The focus currently is on implementing high-quality vaccination campaigns in areas of these countries with populations at highest risk, in an attempt to interrupt polio transmission by mid-2005.

No cases caused by indigenous WPV type 2 have been reported in the world since September 1999. Epidemiologic and virologic evidence suggest that WPV type 3 might no longer circulate in Egypt and, since the second half of 2004, in most areas in northern India where polio is endemic. Because of the probable absence of WPV type 3, monovalent oral polio vaccine type 1 (mOPV1) will be used as an additional tool to interrupt the last chains of WPV type 1 transmission in these countries. This vaccine elicits a higher population immune response per dose against WPV type 1 than the trivalent OPV and will be used in high-transmission areas of India during April–May 2005 and nationwide in Egypt in May and in selected SIAs in the future.

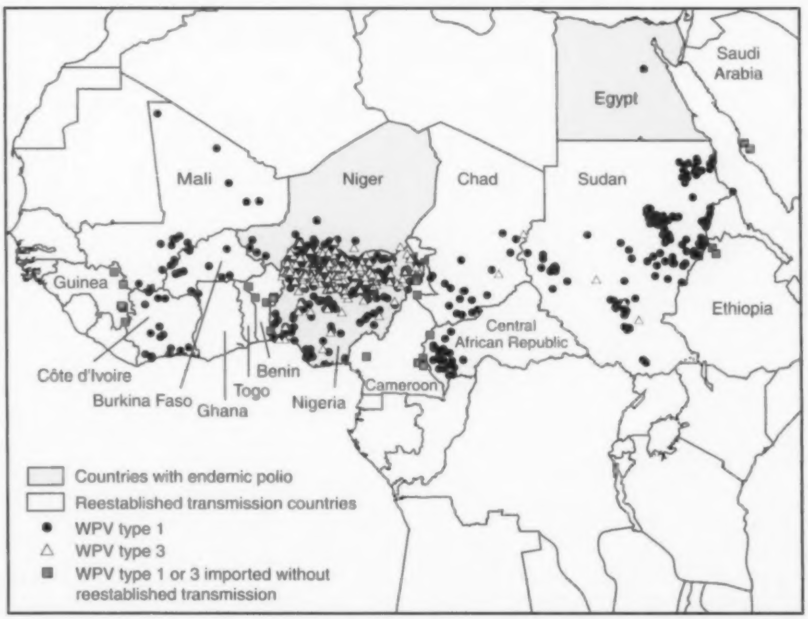
Synchronized vaccination campaigns in 2000 and 2001 succeeded in halting WPV transmission in all western and

FIGURE 1. Virus-confirmed cases of poliomyelitis, by location and wild poliovirus (WPV) type — Afghanistan, India, and Pakistan, January 2004–March 2005*



* Data as reported to the World Health Organization, as of April 12, 2005.

FIGURE 2. Virus-confirmed cases of poliomyelitis, by location and wild poliovirus (WPV) type — northern Africa and Saudi Arabia, January 2004–March 2005*



* Botswana also reported a polio case in 2004 caused by imported poliovirus from the Nigeria-Niger reservoir. Togo and Ghana reported cases in 2003. Data as reported to the World Health Organization, as of April 12, 2005.

central African countries except Nigeria and Niger, where endemic transmission has continued. The resurgence of polio in Africa that occurred in 2003–2004 followed a decrease in the number, extent, and quality of SIAs in many countries. To counteract the resurgence of polio, the quality of vaccination campaigns must be improved, particularly in Nigeria and Niger. Countries in Africa will continue to synchronize their polio NIDs during 2005–2006. Progress in Africa could be substantial if 1) NID quality improves and is sustained, 2) synchronized NIDs cover all countries, and 3) remaining gaps in surveillance are closed.

The genetic evidence of surveillance gaps, most pronounced in Chad and Sudan, where low-intensity WPV type 1 and type 3 circulation went undetected for prolonged periods, is of substantial concern because of its implications for the final precertification phase of polio eradication (CDC, unpublished data, 2005). All countries must closely monitor surveillance quality by using performance indicators for subnational areas to detect and correct any remaining problems affecting surveillance sensitivity; this will ensure rapid detection of circulating virus or importation and timely response.

In areas of both Asia and Africa, the greatest risk to polio eradication is a continued failure to vaccinate all children at high risk, because of limited supervision, cultural or geographic hindrances, or conflict. Certain population subgroups continue to be missed with vaccination because of their minority status and limited access to health services. Full commitment of governmental, traditional, and religious leaders at all levels is critical to ensure all children are vaccinated during polio immunization rounds, with particular effort to increase detailed planning and supervision in areas with populations at high

risk. Conflicts in Côte d'Ivoire and Sudan pose added challenges to reaching the eradication goal.

In January 2004, the Global Polio Eradication Initiative, in consultation with ministers of health of countries where polio is endemic, discussed a revised target of complete global interruption of poliovirus transmission by the end of 2005. With sufficient financing, political commitment, and motivation of health workers, global eradication is nearly in reach. However, the eradication partnership might be critically challenged if the end of 2005 finds 1) continued poliovirus transmission in the remaining high-risk districts in Afghanistan, India, and Pakistan; 2) delay in the control and interruption of WPV transmission in currently affected African countries; or 3) continued expansion of the epidemic in Africa to additional countries. The initiative will be aided in the final push by selective use of mOPV1 and improved efforts to reach every child in underserved population subgroups. In view of the investments already made in polio eradication, concerted efforts in 2005 by governments, health workers, volunteers, and local and international polio partners are imperative to reach the goal of interrupting poliovirus transmission.

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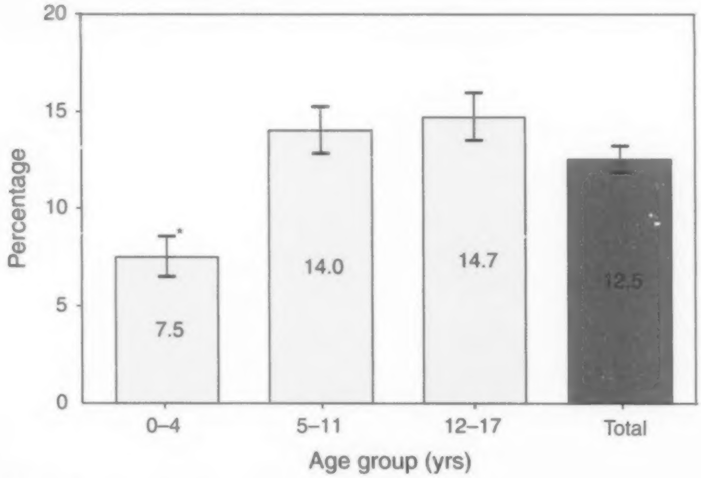
QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Children Aged <18 years Who Have Ever Had Asthma Diagnosed, by Age Group — United States, 2003

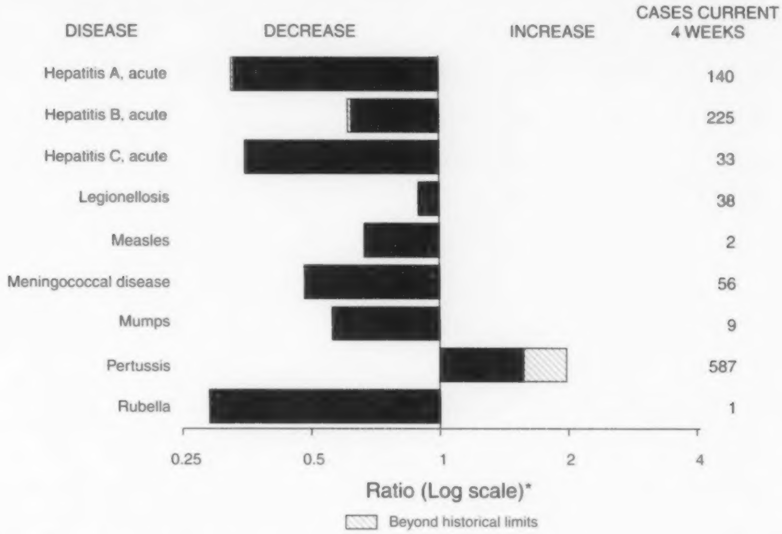


* 95% confidence interval.

An estimated 9 million (12.5%) children aged <18 years in the United States have had asthma diagnosed at some time in their lives. As age increases, the proportion of children who have ever had asthma diagnosed increases.

SOURCE: Dey AN, Bloom B. Summary health statistics for U.S. children: National Health Interview Survey, 2003. Vital Health Stat 2005;10(223). Available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_223.pdf.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals April 23, 2005, with historical data



* Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending April 23, 2005 (16th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal[†]	32	17
Botulism:			HIV infection, pediatric[†¶]	104	72
foodborne	4	4	Influenza-associated pediatric mortality[†**]	30	—
infant	11	23	Measles	10[††]	14[§§]
other (wound & unspecified)	5	2	Mumps	74	59
Brucellosis	17	32	Plague	—	—
Chancroid	9	12	Poliomyelitis, paralytic	—	—
Cholera	—	2	Psittacosis[†]	6	2
Cyclosporiasis[†]	12	97	Q fever[†]	19	16
Diphtheria	—	—	Rabies, human	1	—
Domestic arboviral diseases			Rubella	5	7
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup[†§]	—	2	SARS[†**]	—	—
eastern equine[†§]	—	—	Smallpox[†]	—	—
Powassan[†§]	—	—	*Staphylococcus aureus*:		
St. Louis[†§]	—	—	Vancomycin-intermediate (VISA)[†]	—	—
western equine[†§]	—	—	Vancomycin-resistant (VRSA)[†]	—	—
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome[†]	37	53
human granulocytic (HGE)[†]	22	21	Tetanus	2	3
human monocytic (HME)[†]	23	15	Toxic-shock syndrome	27	32
human, other and unspecified[†]	6	1	Trichinellosis[¶¶]	5	—
Hansen disease[†]	12	27	Tularemia[†]	3	6
Hantavirus pulmonary syndrome[†]	3	3	Yellow fever	—	—

—: No reported cases.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update March 27, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of 10 cases reported, five were indigenous and five were imported from another country.
§§ Of 14 cases reported, five were indigenous and nine were imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending April 23, 2005, and April 24, 2004 (16th Week)*

Reporting area	AIDS		Chlamydia†		Coccidioidomycosis		Cryptosporidiosis	
	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	10,042	8,762	250,327	280,478	1,288	1,635	497	755
NEW ENGLAND	406	311	7,915	9,364	—	—	29	40
Maine	3	5	698	592	N	N	3	6
N.H.	2	10	548	529	—	—	4	10
Vt.¶	1	8	320	363	—	—	8	5
Mass.	211	84	4,468	4,235	—	—	9	12
R.I.	34	33	1,035	1,100	—	—	1	1
Conn.	155	171	846	2,545	N	N	4	6
MID. ATLANTIC	1,995	1,292	29,688	34,911	—	—	73	131
Upstate N.Y.	188	132	6,332	6,553	N	N	19	26
N.Y. City	1,137	381	9,013	11,027	—	—	17	39
N.J.	357	386	3,251	5,679	N	N	6	9
Pa.	313	393	11,092	11,652	N	N	31	57
E.N. CENTRAL	915	804	36,899	51,332	2	5	89	195
Ohio	136	227	8,437	12,979	N	N	37	45
Ind.	119	116	5,780	5,588	N	N	5	26
Ill.	482	281	10,544	14,679	—	—	—	32
Mich.	135	131	7,110	12,513	2	5	15	40
Wis.	43	49	5,028	5,573	N	N	32	52
W.N. CENTRAL	227	218	15,501	17,273	3	4	72	78
Minn.	69	45	2,552	3,493	3	N	18	31
Iowa	18	9	1,637	2,106	N	N	15	12
Mo.	99	100	6,875	6,445	—	3	25	15
N. Dak.	5	11	254	557	N	N	—	—
S. Dak.	5	—	842	772	—	—	5	9
Nebr.¶	2	8	1,344	1,651	—	1	1	2
Kans.	29	45	1,997	2,249	N	N	8	9
S. ATLANTIC	3,395	3,420	49,777	53,331	—	—	112	145
Del.	51	41	1,006	934	N	N	—	—
Md.	406	340	5,383	5,925	—	—	5	7
D.C.	176	148	1,139	1,151	—	—	1	3
Va.¶	177	135	6,979	7,038	—	—	10	15
W. Va.	19	29	697	897	N	N	4	2
N.C.	298	236	10,459	8,425	N	N	14	30
S.C.¶	133	203	6,675	5,927	—	—	5	5
Ga.	503	509	4,447	10,397	—	—	33	46
Fla.	1,632	1,779	12,992	12,637	N	N	40	37
E.S. CENTRAL	581	442	17,838	16,217	—	3	10	35
Ky.	70	41	3,788	1,764	N	N	3	8
Tenn.¶	232	187	6,481	6,915	N	N	2	12
Ala.¶	168	124	1,859	3,960	—	—	4	9
Miss.	111	90	5,710	3,578	—	3	1	6
W.S. CENTRAL	1,021	1,290	34,245	35,313	—	2	14	25
Ark.	69	44	2,717	2,476	—	1	—	7
La.	170	279	5,646	7,727	—	1	2	—
Okla.	72	36	3,333	3,190	N	N	7	7
Tex.¶	710	931	22,549	21,920	N	N	5	11
MOUNTAIN	398	253	16,342	15,485	859	1,061	32	32
Mont.	3	—	679	529	N	N	4	3
Idaho¶	3	2	731	980	N	N	1	4
Wyo.	—	3	356	337	—	—	2	2
Colo.	83	47	3,961	3,748	N	N	11	15
N. Mex.	42	20	748	2,517	2	9	2	1
Ariz.	166	104	6,732	4,928	829	1,023	3	5
Utah	20	19	1,249	974	2	10	4	1
Nev.¶	81	58	1,886	1,472	26	19	5	1
PACIFIC	1,104	732	42,122	47,252	424	560	66	74
Wash.	106	127	5,973	5,307	N	N	5	—
Oreg.¶	66	50	2,649	2,443	—	—	11	7
Calif.	897	517	30,903	36,429	424	560	50	66
Alaska	7	7	1,195	1,233	—	—	—	—
Hawaii	28	31	1,402	1,840	—	—	—	1
Guam	1	—	—	294	—	—	—	—
P.R.	259	142	1,342	696	N	N	N	N
V.I.	7	2	32	125	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update March 27, 2005.

¶ Contains data reported through National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 23, 2005, and April 24, 2004 (16th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC) O157:H7 Cum. 2005	O157:H7 Cum. 2004	Shiga toxin positive, serogroup non-O157 Cum. 2005	Shiga toxin positive, serogroup non-O157 Cum. 2004	Shiga toxin positive, not serogrouped Cum. 2005	Shiga toxin positive, not serogrouped Cum. 2004	Giardiasis Cum. 2005	Giardiasis Cum. 2004	Gonorrhea Cum. 2005	Gonorrhea Cum. 2004
UNITED STATES	297	298	40	53	50	35	4,248	4,829	84,244	97,943
NEW ENGLAND	21	17	8	15	8	3	403	422	1,470	2,191
Maine	2	—	1	—	—	—	41	35	44	84
N.H.	2	3	1	—	—	—	18	16	39	41
Vt.	1	—	—	—	—	—	49	27	12	24
Mass.	5	7	1	5	8	3	170	217	906	975
R.I.	1	2	—	—	—	—	21	33	162	301
Conn.	10	5	5	10	—	—	104	94	307	766
MID. ATLANTIC	33	25	3	4	1	9	767	1,081	8,600	11,188
Upstate N.Y.	15	8	3	1	—	3	253	290	1,941	2,167
N.Y. City	1	6	—	—	—	—	203	357	2,199	3,512
N.J.	9	2	—	1	—	3	106	136	1,216	2,081
Pa.	8	9	—	2	1	3	205	298	3,244	3,428
E.N. CENTRAL	60	71	6	11	3	4	585	746	14,301	20,934
Ohio	23	17	1	—	2	4	176	224	4,089	6,677
Ind.	8	14	—	—	—	—	N	N	2,202	1,947
Ill.	6	16	1	—	—	—	92	244	4,044	6,075
Mich.	10	10	—	2	1	—	173	167	2,619	4,890
Wis.	13	14	4	9	—	—	144	111	1,347	1,345
W.N. CENTRAL	40	47	6	7	7	7	551	529	5,067	5,540
Minn.	4	20	2	3	2	—	264	168	742	1,296
Iowa	9	6	—	—	—	—	66	67	346	381
Mo.	14	3	2	4	2	2	118	170	2,866	2,634
N. Dak.	1	2	—	—	—	3	1	8	15	47
S. Dak.	2	2	—	—	—	—	25	19	107	84
Nebr.	5	7	2	—	1	—	33	47	320	338
Kans.	5	7	—	—	2	2	44	50	671	760
S. ATLANTIC	58	33	8	7	24	7	752	757	21,409	23,657
Del.	—	—	N	N	N	N	4	16	239	310
Md.	5	4	2	—	—	2	47	28	2,043	2,508
D.C.	—	—	—	—	—	—	13	27	614	746
Va.	2	1	3	5	6	—	163	105	2,544	2,844
W. Va.	—	1	—	—	—	—	8	9	212	246
N.C.	—	—	—	—	12	4	N	N	5,330	4,576
S.C.	1	3	—	—	—	—	26	22	2,879	2,895
Ga.	7	11	1	1	—	—	241	228	1,973	4,360
Fla.	43	13	2	1	6	1	250	322	5,575	5,172
E.S. CENTRAL	15	12	—	1	4	4	106	90	6,540	7,276
Ky.	1	4	—	1	3	2	N	N	1,183	731
Tenn.	8	3	—	—	1	2	50	39	2,327	2,496
Ala.	6	1	—	—	—	—	56	51	1,322	2,235
Miss.	—	4	—	—	—	—	—	—	1,708	1,814
W.S. CENTRAL	5	20	1	3	2	1	65	83	13,394	13,187
Ark.	1	1	—	1	—	—	25	38	1,389	1,125
La.	—	1	1	—	2	—	8	14	3,019	3,633
Okla.	1	3	—	—	—	—	32	31	1,417	1,372
Tex.	3	15	—	2	—	1	N	N	7,569	7,057
MOUNTAIN	32	32	8	4	1	—	332	353	3,439	3,433
Mont.	2	3	—	—	—	—	9	11	37	18
Idaho	3	6	5	1	—	—	31	49	31	25
Wyo.	—	—	1	—	—	—	6	3	16	18
Colo.	10	6	1	1	—	—	117	113	880	910
N. Mex.	—	5	1	1	—	—	12	19	141	303
Ariz.	6	4	N	N	N	N	54	68	1,418	1,418
Utah	4	5	—	—	—	—	82	69	204	117
Nev.	7	3	—	1	1	—	21	21	712	624
PACIFIC	33	41	—	1	—	—	687	768	10,024	10,537
Wash.	6	6	—	—	—	—	53	64	1,062	837
Oreg.	2	7	—	1	—	—	64	123	487	305
Calif.	20	24	—	—	—	—	529	531	8,061	8,718
Alaska	2	1	—	—	—	—	19	22	153	226
Hawaii	3	3	—	—	—	—	22	28	261	451
Guam	N	N	—	—	—	—	—	—	—	57
P.R.	—	—	—	—	—	—	10	11	125	70
V.I.	—	—	—	—	—	—	—	—	2	44
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 23, 2005, and April 24, 2004 (16th Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	719	704	2	3	37	36	70	70
NEW ENGLAND	50	64	—	1	4	5	2	—
Maine	2	5	—	—	—	—	—	—
N.H.	—	11	—	—	—	2	—	—
Vt.	6	4	—	—	—	—	2	—
Mass.	19	32	—	1	—	2	—	—
R.I.	6	1	—	—	2	—	—	—
Conn.	17	11	—	—	2	1	—	—
MID. ATLANTIC	140	147	—	—	—	2	19	19
Upstate N.Y.	43	48	—	—	—	2	4	2
N.Y. City	23	29	—	—	—	—	6	6
N.J.	29	29	—	—	—	—	5	2
Pa.	45	41	—	—	—	—	4	9
E.N. CENTRAL	92	130	—	—	—	6	3	21
Ohio	49	46	—	—	—	2	2	7
Ind.	25	18	—	—	—	3	1	1
Ill.	4	35	—	—	—	—	—	9
Mich.	9	9	—	—	—	1	—	3
Wis.	5	22	—	—	—	—	—	1
W.N. CENTRAL	35	31	—	—	2	2	6	4
Minn.	16	12	—	—	2	2	—	—
Iowa	—	1	—	—	—	—	—	1
Mo.	15	12	—	—	—	—	4	3
N. Dak.	1	1	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	2	4	—	—	—	—	1	—
Kans.	1	1	—	—	—	—	—	—
S. ATLANTIC	201	162	1	—	8	7	13	9
Del.	—	—	—	—	—	—	—	—
Md.	31	32	—	—	3	1	1	—
D.C.	—	—	—	—	—	—	—	—
Va.	17	12	—	—	—	—	—	—
W. Va.	13	8	—	—	1	3	2	—
N.C.	25	17	—	—	2	1	—	—
S.C.	8	2	—	—	—	—	1	—
Ga.	55	47	—	—	—	—	6	9
Fla.	52	44	1	—	2	2	3	—
E.S. CENTRAL	34	23	—	—	1	—	6	5
Ky.	2	—	—	—	1	—	—	—
Tenn.	25	15	—	—	—	—	4	4
Ala.	7	8	—	—	—	—	2	1
Miss.	—	—	—	—	—	—	—	—
W.S. CENTRAL	40	30	1	—	2	4	5	—
Ark.	—	—	—	—	—	—	—	—
La.	15	8	1	—	—	—	5	—
Okla.	25	22	—	—	2	4	—	—
Tex.	—	—	—	—	—	—	—	—
MOUNTAIN	98	84	—	2	14	8	13	10
Mont.	—	—	—	—	—	—	—	—
Idaho	2	2	—	—	—	—	1	1
Wyo.	1	—	—	—	—	—	—	—
Colo.	24	20	—	—	—	—	3	2
N. Mex.	10	20	—	—	4	3	—	4
Ariz.	42	35	—	—	8	5	2	1
Utah	9	5	—	2	—	—	5	1
Nev.	10	2	—	—	2	—	2	1
PACIFIC	29	33	—	—	6	2	3	2
Wash.	—	1	—	—	—	—	—	1
Oreg.	16	18	—	—	—	—	3	—
Calif.	9	9	—	—	6	2	—	1
Alaska	1	1	—	—	—	—	—	—
Hawaii	3	4	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 23, 2005, and April 24, 2004 (16th Week)*

	Hepatitis (viral, acute), by type					
	A		B		C	
Reporting area	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,077	1,859	1,701	1,793	178	246
NEW ENGLAND	169	277	92	120	4	4
Maine	—	7	4	1	—	—
N.H.	15	7	4	15	—	—
Vt.	—	5	1	1	4	1
Mass.	129	226	70	61	—	3
R.I.	5	6	—	1	—	—
Conn.	20	26	13	41	—	—
MID. ATLANTIC	171	229	401	242	31	35
Upstate N.Y.	29	28	38	22	8	1
N.Y. City	80	85	23	58	—	—
N.J.	27	47	275	58	—	—
Pa.	35	69	65	104	23	34
E.N. CENTRAL	102	170	117	147	37	19
Ohio	23	17	47	48	—	2
Ind.	7	13	7	9	7	1
Ill.	21	71	7	—	—	4
Mich.	41	50	56	74	30	12
Wis.	10	19	—	16	—	—
W.N. CENTRAL	38	46	80	109	13	1
Minn.	3	10	—	8	—	1
Iowa	6	10	8	5	—	—
Mo.	22	8	52	78	12	—
N. Dak.	—	1	—	1	1	—
S. Dak.	—	2	—	—	—	—
Nebr.	2	10	13	10	—	—
Kans.	5	5	7	7	—	—
S. ATLANTIC	182	322	523	571	47	64
Del.	—	3	21	13	—	2
Md.	15	52	56	49	12	5
D.C.	2	3	—	5	—	2
Va.	28	25	67	60	6	9
W. Va.	—	1	10	2	3	3
N.C.	26	22	52	57	7	5
S.C.	7	15	36	34	1	4
Ga.	37	127	103	182	2	6
Fla.	67	74	178	169	16	28
E.S. CENTRAL	46	57	99	150	21	28
Ky.	3	9	25	16	—	11
Tenn.	27	31	41	62	7	5
Ala.	7	5	19	21	6	1
Miss.	9	12	14	51	8	11
W.S. CENTRAL	37	264	71	83	6	69
Ark.	1	36	14	38	—	—
La.	19	9	13	26	4	39
Okla.	2	13	5	18	—	2
Tex.	15	206	39	1	2	28
MOUNTAIN	126	147	153	126	6	9
Mont.	6	3	—	—	—	2
Idaho	11	8	5	3	—	—
Wyo.	—	—	—	3	—	—
Colo.	13	12	10	17	—	—
N. Mex.	5	5	5	7	—	3
Ariz.	74	96	105	62	—	2
Utah	12	21	20	16	4	—
Nev.	5	2	8	18	2	2
PACIFIC	206	347	165	245	13	17
Wash.	15	16	15	22	2	2
Oreg.	10	26	29	38	6	5
Calif.	171	296	118	181	5	8
Alaska	3	2	2	2	—	—
Hawaii	7	7	1	2	—	2
Guam	—	1	—	4	—	—
P.R.	2	9	3	16	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 23, 2005, and April 24, 2004 (16th Week)*

	Legionellosis		Listeriosis		Lyme disease		Malaria	
Reporting area	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	304	327	126	136	1,506	2,300	284	331
NEW ENGLAND	14	6	2	8	74	227	12	27
Maine	1	—	—	1	2	30	—	—
N.H.	2	—	1	1	14	9	2	—
Vt.	—	—	—	—	1	7	—	1
Mass.	7	3	—	2	51	126	9	19
R.I.	1	1	—	1	1	18	1	2
Conn.	3	2	1	3	5	37	—	5
MID. ATLANTIC	89	68	25	31	1,058	1,697	72	79
Upstate N.Y.	25	13	7	8	168	559	16	11
N.Y. City	5	6	5	3	—	—	33	37
N.J.	19	11	5	11	455	325	15	16
Pa.	40	38	8	9	435	813	8	15
E.N. CENTRAL	63	83	18	19	32	68	15	23
Ohio	32	36	7	7	20	13	3	6
Ind.	1	9	1	2	2	—	—	3
Ill.	8	14	—	3	—	4	3	5
Mich.	18	22	5	5	2	—	7	4
Wis.	4	2	5	2	8	51	2	5
W.N. CENTRAL	11	8	11	3	40	24	12	20
Minn.	1	—	2	1	35	7	3	8
Iowa	—	2	4	1	2	5	2	1
Mo.	8	4	2	1	2	12	6	4
N. Dak.	1	1	2	—	—	—	—	1
S. Dak.	—	1	—	—	—	—	—	1
Nebr.	—	—	—	—	—	—	—	1
Kans.	1	—	1	—	1	—	1	4
S. ATLANTIC	69	73	32	20	263	231	73	94
Del.	1	2	N	N	62	31	—	2
Md.	17	10	4	4	135	133	22	23
D.C.	1	2	—	—	1	5	2	4
Va.	5	5	1	1	25	8	7	7
W. Va.	3	2	—	1	2	1	1	—
N.C.	7	7	8	4	15	33	9	5
S.C.	1	2	—	—	5	1	3	5
Ga.	6	7	7	4	—	5	13	16
Fla.	28	36	12	6	18	14	16	32
E.S. CENTRAL	6	15	5	8	5	9	9	8
Ky.	1	3	—	2	—	2	2	1
Tenn.	1	7	2	5	5	2	5	1
Ala.	4	5	3	—	—	—	2	5
Miss.	—	—	—	1	—	5	—	1
W.S. CENTRAL	4	30	3	15	10	17	22	28
Ark.	1	—	—	1	—	—	1	1
La.	3	2	1	1	—	1	—	2
Okla.	—	2	—	—	—	—	2	1
Tex.	—	26	2	13	10	16	19	24
MOUNTAIN	27	22	—	3	2	6	14	12
Mont.	1	—	—	—	—	—	—	—
Idaho	1	1	—	1	—	1	—	—
Wyo.	2	4	—	—	—	2	1	—
Colo.	6	3	—	1	—	—	8	5
N. Mex.	1	—	—	—	—	—	—	1
Ariz.	7	5	—	—	—	1	2	1
Utah	4	8	—	—	2	2	3	3
Nev.	5	1	—	1	—	—	—	2
PACIFIC	21	22	30	29	22	21	55	40
Wash.	—	3	2	5	—	2	3	1
Oreg.	N	N	2	4	2	8	1	7
Calif.	21	19	26	20	19	11	45	31
Alaska	—	—	—	—	1	—	2	—
Hawaii	—	—	—	—	N	N	4	1
Guam	—	—	—	—	—	—	—	—
P.R.	—	1	—	—	N	N	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

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* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 23, 2005, and April 24, 2004 (16th Week)*

Reporting area	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	411	537	33	36	25	17	1	—	352	484
NEW ENGLAND	28	26	1	4	—	—	—	—	27	22
Maine	1	7	—	—	—	—	—	—	1	7
N.H.	3	3	—	—	—	—	—	—	3	3
Vt.	3	1	—	—	—	—	—	—	3	1
Mass.	11	15	—	4	—	—	—	—	11	11
R.I.	2	—	—	—	—	—	—	—	2	—
Conn.	8	—	1	—	—	—	—	—	7	—
MID. ATLANTIC	56	80	15	21	4	5	—	—	37	54
Upstate N.Y.	15	24	1	3	3	3	—	—	11	18
N.Y. City	6	16	—	—	—	—	—	—	6	16
N.J.	15	13	—	—	—	—	—	—	15	13
Pa.	20	27	14	18	1	2	—	—	5	7
E.N. CENTRAL	37	51	10	8	4	3	—	—	23	40
Ohio	17	28	—	3	4	3	—	—	13	22
Ind.	5	9	—	—	—	—	—	—	5	9
Ill.	—	1	—	—	—	—	—	—	—	1
Mich.	10	5	10	5	—	—	—	—	—	—
Wis.	5	8	—	—	—	—	—	—	5	8
W.N. CENTRAL	28	26	2	—	1	1	—	—	25	25
Minn.	5	8	1	—	—	—	—	—	4	8
Iowa	9	4	—	—	1	—	—	—	8	4
Mo.	7	9	1	—	—	1	—	—	6	8
N. Dak.	—	—	—	—	—	—	—	—	—	—
S. Dak.	1	1	—	—	—	—	—	—	1	1
Nebr.	2	1	—	—	—	—	—	—	2	1
Kans.	4	3	—	—	—	—	—	—	4	3
S. ATLANTIC	74	98	2	2	4	2	—	—	68	94
Del.	—	1	—	—	—	—	—	—	—	1
Md.	7	5	1	—	2	—	—	—	4	5
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	9	3	—	—	—	—	—	—	9	3
W. Va.	2	3	—	—	—	—	—	—	2	3
N.C.	7	14	1	—	2	2	—	—	4	12
S.C.	9	9	—	—	—	—	—	—	9	9
Ga.	8	6	—	—	—	—	—	—	8	6
Fla.	32	52	—	—	—	—	—	—	32	52
E.S. CENTRAL	23	24	—	—	2	—	—	—	21	24
Ky.	8	3	—	—	2	—	—	—	6	3
Tenn.	10	9	—	—	—	—	—	—	10	9
Ala.	1	6	—	—	—	—	—	—	1	6
Miss.	4	6	—	—	—	—	—	—	4	6
W.S. CENTRAL	35	58	1	1	3	1	—	—	31	56
Ark.	8	10	—	—	—	—	—	—	8	10
La.	13	17	—	1	2	—	—	—	11	16
Okla.	6	3	1	—	1	1	—	—	4	2
Tex.	8	28	—	—	—	—	—	—	8	28
MOUNTAIN	32	27	1	—	3	3	1	—	27	24
Mont.	—	1	—	—	—	—	—	—	—	1
Idaho	1	3	—	—	—	—	—	—	1	3
Wyo.	—	2	—	—	—	—	—	—	—	2
Colo.	10	9	1	—	—	—	1	—	8	9
N. Mex.	1	4	—	—	—	2	—	—	1	2
Ariz.	16	4	—	—	2	—	—	—	14	4
Utah	2	2	—	—	1	—	—	—	1	2
Nev.	2	2	—	—	—	1	—	—	2	1
PACIFIC	98	147	1	—	4	2	—	—	93	145
Wash.	19	8	1	—	3	2	—	—	15	6
Oreg.	21	29	—	—	—	—	—	—	21	29
Calif.	50	103	—	—	—	—	—	—	50	103
Alaska	2	2	—	—	—	—	—	—	2	2
Hawaii	6	5	—	—	1	—	—	—	5	5
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	—	3	—	—	—	—	—	—	—	3
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	—	—	—	—	—	—	—	—	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

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* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending April 23, 2005, and April 24, 2004 (16th Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	4,651	2,831	1,394	1,783	171	150	6,567	7,743	2,679	3,372
NEW ENGLAND	236	476	231	131	1	5	398	367	55	65
Maine	11	—	17	11	N	N	24	18	1	1
N.H.	—	15	2	6	—	—	24	25	4	3
Vt.	41	22	13	5	—	—	28	17	3	1
Mass.	165	418	153	50	—	5	210	206	31	43
R.I.	5	9	5	10	1	—	15	24	2	2
Conn.	14	12	41	49	—	—	97	77	14	15
MID. ATLANTIC	494	696	164	193	11	16	794	1,032	299	379
Upstate N.Y.	176	494	112	86	—	—	211	226	87	154
N.Y. City	18	53	9	2	1	7	220	322	117	112
N.J.	77	40	N	N	2	—	126	180	79	69
Pa.	223	109	43	105	8	9	237	304	16	44
E.N. CENTRAL	1,179	441	13	6	2	5	632	1,263	150	290
Ohio	571	131	4	2	1	2	226	271	18	51
Ind.	98	20	2	2	—	1	49	101	26	46
Ill.	67	16	2	1	—	1	30	475	4	130
Mich.	55	31	5	1	1	1	174	195	79	33
Wis.	388	243	—	—	—	—	153	221	23	30
W.N. CENTRAL	601	153	87	155	10	4	504	495	214	105
Minn.	99	29	16	16	—	—	133	126	16	14
Iowa	157	29	23	14	—	—	83	87	37	29
Mo.	142	73	10	3	10	4	148	140	124	27
N. Dak.	40	5	4	18	—	—	11	11	2	1
S. Dak.	1	7	5	24	—	—	31	21	8	6
Nebr.	66	—	—	46	—	—	41	44	20	7
Kans.	96	10	29	34	—	—	57	66	7	21
S. ATLANTIC	317	157	458	789	117	94	1,951	1,642	505	901
Del.	2	—	—	9	1	2	10	15	3	3
Md.	59	36	81	93	6	3	152	130	22	31
D.C.	1	4	—	—	—	—	13	12	4	14
Va.	59	42	175	133	3	—	195	169	26	30
W. Va.	20	2	6	19	1	—	22	29	—	—
N.C.	21	29	142	192	82	73	333	225	54	121
S.C.	93	17	5	44	5	4	129	100	35	140
Ga.	12	8	44	94	11	10	320	265	148	184
Fla.	50	19	5	205	8	2	777	697	213	378
E.S. CENTRAL	125	29	27	64	4	19	337	408	353	164
Ky.	31	6	3	7	—	—	47	71	33	25
Tenn.	54	15	5	36	3	7	124	123	204	63
Ala.	28	4	19	17	1	2	121	130	90	55
Miss.	12	4	—	4	—	10	45	84	26	21
W.S. CENTRAL	104	98	335	377	4	3	394	755	494	834
Ark.	48	10	10	18	—	—	77	71	14	14
La.	3	2	—	—	1	3	93	106	30	96
Okla.	—	10	34	35	3	—	62	63	171	106
Tex.	53	76	291	324	—	—	162	515	279	618
MOUNTAIN	1,123	315	54	24	20	1	493	571	181	232
Mont.	244	4	—	3	1	—	23	28	2	3
Idaho	36	14	—	—	—	—	23	45	—	4
Wyo.	7	3	7	—	1	—	10	16	—	1
Colo.	529	167	1	—	—	1	127	131	31	37
N. Mex.	41	50	—	—	—	—	34	63	23	42
Ariz.	127	54	46	21	15	—	178	191	88	116
Utah	124	22	—	—	3	—	53	66	13	13
Nev.	15	1	—	—	—	—	45	31	24	16
PACIFIC	472	466	25	44	2	3	1,064	1,210	428	402
Wash.	126	100	—	—	—	—	101	62	20	18
Oreg.	209	111	—	—	—	2	74	95	21	17
Calif.	93	240	24	34	2	1	808	944	374	349
Alaska	15	9	1	10	—	—	14	26	4	4
Hawaii	29	6	—	—	—	—	67	83	9	14
Guam	—	—	—	—	—	—	—	12	—	16
P.R.	—	1	26	16	N	N	28	55	—	1
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) **Provisional cases of selected notifiable diseases, United States, weeks ending April 23, 2005, and April 24, 2004 (16th Week)***

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease				Syphilis			
			Drug resistant, all ages		Age <5 years		Primary & secondary		Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,501	1,701	961	953	268	292	1,913	2,298	79	121
NEW ENGLAND	57	82	9	13	25	37	56	48	—	—
Maine	2	3	N	N	—	—	1	—	—	—
N.H.	4	9	—	—	1	N	4	1	—	—
Vt.	6	4	3	4	2	1	—	—	—	—
Mass.	39	61	—	4	22	34	45	30	—	—
R.I.	6	5	6	5	—	2	2	1	—	—
Conn.	—	—	—	—	U	U	4	16	—	—
MID. ATLANTIC	330	299	96	63	54	39	239	308	16	16
Upstate N.Y.	123	95	36	25	34	24	22	20	12	1
N.Y. City	42	54	U	U	U	U	156	189	3	7
N.J.	69	58	N	N	9	4	36	56	1	7
Pa.	96	92	60	38	11	11	25	43	—	1
E.N. CENTRAL	248	399	232	226	62	78	154	251	10	25
Ohio	86	102	158	172	29	37	65	70	2	1
Ind.	32	37	74	54	18	16	17	12	1	1
Ill.	2	112	—	—	11	—	43	106	1	6
Mich.	120	115	—	N	—	N	23	52	5	17
Wis.	8	33	N	N	4	25	6	11	1	—
W.N. CENTRAL	112	138	18	8	30	29	57	52	—	—
Minn.	41	62	—	—	15	17	7	9	—	—
Iowa	N	N	N	N	—	N	1	2	—	—
Mo.	35	32	16	7	1	6	43	31	—	—
N. Dak.	2	4	—	—	1	—	—	—	—	—
S. Dak.	9	8	2	1	—	—	—	—	—	—
Nebr.	8	10	—	—	2	4	2	5	—	—
Kans.	17	22	N	N	11	2	4	5	—	—
S. ATLANTIC	322	330	414	483	36	20	522	584	16	18
Del.	—	2	1	3	—	N	5	2	—	—
Md.	92	56	—	—	26	15	99	94	6	3
D.C.	2	2	11	6	2	4	33	25	—	1
Va.	23	17	N	N	—	N	30	14	3	1
W. Va.	3	11	30	46	8	1	2	3	—	—
N.C.	44	45	N	N	U	U	73	44	2	1
S.C.	9	27	—	45	—	N	22	43	—	4
Ga.	64	94	152	130	—	N	37	117	—	1
Fla.	85	76	220	253	—	N	221	242	5	7
E.S. CENTRAL	65	87	67	60	3	—	110	112	10	4
Ky.	17	31	11	15	N	N	8	17	—	—
Tenn.	48	56	56	45	—	N	42	46	8	1
Ala.	—	—	—	—	—	N	51	37	2	2
Miss.	—	—	—	—	3	—	9	12	—	1
W.S. CENTRAL	73	130	60	30	32	66	361	357	19	30
Ark.	7	4	6	5	5	4	14	14	—	3
La.	4	1	54	25	8	17	63	80	2	2
Okla.	52	23	N	N	13	20	12	7	1	2
Tex.	10	102	N	N	6	25	272	256	16	23
MOUNTAIN	262	202	37	16	26	23	101	122	8	5
Mont.	—	—	—	—	—	—	5	—	—	—
Idaho	1	3	N	N	—	N	9	8	—	—
Wyo.	1	5	14	4	—	—	—	1	—	—
Colo.	110	36	N	N	25	21	13	21	—	—
N. Mex.	16	43	—	5	—	—	7	32	1	1
Ariz.	102	100	N	N	—	N	42	53	7	4
Utah	31	15	22	5	1	2	2	2	—	—
Nev.	1	—	1	2	—	—	23	5	—	—
PACIFIC	32	34	28	54	—	—	313	464	—	23
Wash.	N	N	N	N	N	N	50	23	—	—
Oreg.	N	N	N	N	—	N	10	11	—	—
Calif.	—	—	N	N	N	N	248	426	—	23
Alaska	—	—	—	—	—	N	3	—	—	—
Hawaii	32	34	28	54	—	—	2	4	—	—
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	N	N	N	N	—	N	42	44	5	2
V.I.	—	—	—	—	—	—	—	4	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) **Provisional cases of selected notifiable diseases, United States, weeks ending April 23, 2005, and April 24, 2004 (16th Week)***

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	2,252	3,453	45	71	7,188	7,728	—	1	—
NEW ENGLAND	73	115	3	9	122	306	—	—	—
Maine	6	3	—	—	101	43	—	—	—
N.H.	3	6	—	—	—	—	—	—	—
Vt.	—	—	—	—	20	253	—	—	—
Mass.	49	68	2	8	1	10	—	—	—
R.I.	3	15	—	1	—	—	—	—	—
Conn.	12	23	1	—	—	—	—	—	—
MID. ATLANTIC	549	537	13	19	1,472	22	—	—	—
Upstate N.Y.	55	61	2	1	—	—	—	—	—
N.Y. City	295	271	1	7	—	—	—	—	—
N.J.	127	116	3	8	—	—	—	—	—
Pa.	72	89	7	3	1,472	22	—	—	—
E.N. CENTRAL	345	313	2	4	2,453	2,643	—	—	—
Ohio	71	56	—	1	585	700	—	—	—
Ind.	37	43	—	—	N	N	—	—	—
Ill.	157	148	—	—	8	—	—	—	—
Mich.	58	43	1	3	1,679	1,671	—	—	—
Wis.	22	23	1	—	181	272	—	—	—
W.N. CENTRAL	129	107	1	2	67	107	—	—	—
Minn.	50	39	1	1	—	—	—	—	—
Iowa	11	11	—	—	N	N	—	—	—
Mo.	37	33	—	1	3	2	—	—	—
N. Dak.	2	2	—	—	10	67	—	—	—
S. Dak.	5	3	—	—	54	38	—	—	—
Nebr.	11	6	—	—	—	—	—	—	—
Kans.	13	13	—	—	—	—	—	—	N
S. ATLANTIC	504	647	7	8	686	898	—	—	—
Del.	—	7	—	—	2	3	—	—	—
Md.	62	58	1	2	—	—	—	—	—
D.C.	22	6	—	—	6	11	—	—	—
Va.	66	52	—	2	93	246	—	—	—
W. Va.	8	6	—	—	448	466	—	—	N
N.C.	50	58	1	2	—	N	—	—	—
S.C.	60	51	—	—	137	172	—	—	—
Ga.	32	210	2	—	—	—	—	—	—
Fla.	204	199	3	2	—	—	—	—	—
E.S. CENTRAL	142	145	1	1	—	—	—	—	—
Ky.	33	17	1	—	N	N	—	—	—
Tenn.	76	43	—	1	—	—	—	—	—
Ala.	33	52	—	—	—	—	—	—	—
Miss.	—	33	—	—	—	—	—	—	—
W.S. CENTRAL	61	576	3	7	1,183	2,690	—	—	—
Ark.	24	41	—	—	—	—	—	—	—
La.	—	—	—	—	83	33	—	—	—
Okla.	37	43	—	—	—	—	—	—	—
Tex.	—	492	3	7	1,100	2,657	—	—	—
MOUNTAIN	51	141	2	3	1,205	1,062	—	1	—
Mont.	—	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—
Wyo.	—	1	—	—	39	15	—	—	—
Colo.	8	39	—	1	855	807	—	—	—
N. Mex.	3	11	—	—	68	29	—	—	—
Ariz.	35	51	1	1	—	—	—	1	—
Utah	5	14	1	1	243	211	—	—	—
Nev.	—	25	—	—	—	—	—	—	—
PACIFIC	398	872	13	18	—	—	—	—	—
Wash.	62	61	—	1	N	N	—	—	—
Oreg.	32	26	1	—	—	—	—	—	—
Calif.	254	744	8	12	—	—	—	—	—
Alaska	11	9	—	—	—	—	—	—	—
Hawaii	39	32	4	5	—	—	—	—	—
Guam	—	14	—	—	—	27	—	—	—
P.R.	—	14	—	—	68	111	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	U	—	U	—	U	—	U	—

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).

§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending April 23, 2005 (16th Week)

Reporting Area	All causes, by age (years) All Ages	≥65	45–64	25–44	1–24	<1	P&I[†] Total
NEW ENGLAND	601	429	108	33	9	22	67
Boston, Mass.	164	106	41	4	3	10	20
Bridgeport, Conn.	13	12	1	—	—	—	2
Cambridge, Mass.	10	6	2	2	—	—	—
Fall River, Mass.	23	18	3	2	—	—	2
Hartford, Conn.	58	44	6	2	1	5	6
Lowell, Mass.	27	21	4	2	—	—	4
Lynn, Mass.	10	7	3	—	—	—	1
New Bedford, Mass.	35	28	1	6	—	—	4
New Haven, Conn.	54	34	11	7	1	1	8
Providence, R.I.	57	38	13	2	1	3	5
Somerville, Mass.	2	2	—	—	—	—	—
Springfield, Mass.	35	26	6	—	2	1	6
Waterbury, Conn.	38	29	6	2	1	—	1
Worcester, Mass.	75	58	11	4	—	2	8
MID. ATLANTIC	2,191	1,556	429	134	39	31	149
Albany, N.Y.	45	34	7	2	1	1	1
Allentown, Pa.	27	21	5	1	—	—	1
Buffalo, N.Y.	76	51	15	8	2	—	5
Camden, N.J.	39	25	7	5	1	1	1
Elizabeth, N.J.	14	10	3	—	—	—	1
Erie, Pa.	51	35	15	1	—	—	2
Jersey City, N.J.	42	27	10	4	1	—	—
New York City, N.Y.	1,142	810	227	68	18	18	69
Newark, N.J.	56	29	18	6	3	—	2
Paterson, N.J.	7	3	2	—	1	1	—
Philadelphia, Pa.	312	219	60	24	5	4	27
Pittsburgh, Pa.[§]	34	25	3	3	1	2	—
Reading, Pa.	31	27	2	2	—	—	5
Rochester, N.Y.	128	99	21	2	3	3	15
Schenectady, N.Y.	20	15	4	—	—	1	5
Scranton, Pa.	29	24	4	1	—	—	3
Syracuse, N.Y.	88	69	13	4	2	—	10
Trenton, N.J.	16	9	6	1	—	—	—
Utica, N.Y.	13	10	2	—	1	—	—
Yonkers, N.Y.	21	14	5	2	—	—	2
E.N. CENTRAL	2,173	1,474	481	128	44	45	186
Akron, Ohio	51	36	13	2	—	—	10
Canton, Ohio	49	40	8	—	1	—	9
Chicago, Ill.	313	190	77	25	8	12	26
Cincinnati, Ohio	77	51	18	5	1	2	8
Cleveland, Ohio	280	185	71	15	5	4	12
Columbus, Ohio	231	146	60	19	3	3	15
Dayton, Ohio	173	125	27	9	8	4	19
Detroit, Mich.	161	89	49	13	7	3	13
Evansville, Ind.	41	35	5	1	—	—	6
Fort Wayne, Ind.	72	51	15	4	—	2	5
Gary, Ind.	19	7	10	1	1	—	2
Grand Rapids, Mich.	63	45	13	—	3	2	8
Indianapolis, Ind.	193	141	33	8	3	8	15
Lansing, Mich.	46	36	6	4	—	—	5
Milwaukee, Wis.	103	68	26	6	2	1	13
Peoria, Ill.	53	38	11	2	—	2	2
Rockford, Ill.	49	37	5	5	1	1	1
South Bend, Ind.	65	56	7	2	—	—	6
Toledo, Ohio	80	57	17	5	1	—	5
Youngstown, Ohio	54	41	10	2	—	1	6
W.N. CENTRAL	712	497	141	38	24	12	76
Des Moines, Iowa	146	114	27	1	4	—	25
Duluth, Minn.	36	27	6	2	1	—	5
Kansas City, Kans.	21	15	4	2	—	—	1
Kansas City, Mo.	89	57	19	6	7	—	7
Lincoln, Nebr.	29	21	6	2	—	—	2
Minneapolis, Minn.	72	44	16	8	1	3	9
Omaha, Nebr.	70	46	18	1	4	1	9
St. Louis, Mo.	99	62	20	9	4	4	5
St. Paul, Minn.	66	45	14	5	1	1	6
Wichita, Kans.	84	66	11	2	2	3	7
S. ATLANTIC	1,291	851	289	98	32	19	84
Atlanta, Ga.	129	83	28	11	5	2	8
Baltimore, Md.	298	175	83	26	9	4	35
Charlotte, N.C.	118	81	28	6	1	2	14
Jacksonville, Fla.	U	U	U	U	U	U	U
Miami, Fla.	104	71	19	9	5	—	5
Norfolk, Va.	52	34	9	4	—	5	—
Richmond, Va.	49	34	8	4	1	2	3
Savannah, Ga.	68	49	12	4	1	1	3
St. Petersburg, Fla.	73	52	17	3	1	—	3
Tampa, Fla.	170	126	33	8	3	—	7
Washington, D.C.	201	125	47	20	6	3	3
Wilmington, Del.	29	21	5	3	—	—	3
E.S. CENTRAL	954	604	232	67	27	24	77
Birmingham, Ala.	212	130	51	16	6	9	24
Chattanooga, Tenn.	84	64	15	3	2	—	1
Knoxville, Tenn.	93	66	16	5	4	2	2
Lexington, Ky.	51	30	15	3	1	2	2
Memphis, Tenn.	201	127	50	17	5	2	24
Mobile, Ala.	91	54	28	7	1	1	4
Montgomery, Ala.	55	32	17	4	2	—	7
Nashville, Tenn.	167	101	40	12	6	8	13
W.S. CENTRAL	3,411	2,297	764	199	96	55	189
Austin, Tex.	66	46	10	9	—	1	6
Baton Rouge, La.	74	51	16	5	1	1	2
Corpus Christi, Tex.	55	39	13	1	2	—	7
Dallas, Tex.	198	113	55	17	9	4	16
El Paso, Tex.	114	86	21	6	—	1	5
Ft. Worth, Tex.	130	75	37	9	3	6	8
Houston, Tex.	371	222	91	35	16	7	23
Little Rock, Ark.	86	48	29	6	1	2	4
New Orleans, La.	1,899	1,304	428	91	52	24	89
San Antonio, Tex.	231	166	40	13	7	5	18
Shreveport, La.	60	45	8	2	3	2	4
Tulsa, Okla.	127	102	16	5	2	2	7
MOUNTAIN	995	676	219	62	22	13	75
Albuquerque, N.M.	163	115	29	11	4	4	11
Boise, Idaho	54	44	10	—	—	—	5
Colo. Springs, Colo.	66	49	14	1	—	2	3
Denver, Colo.	97	54	30	7	4	2	6
Las Vegas, Nev.	240	159	55	19	7	—	20
Ogden, Utah	29	20	7	2	—	—	2
Phoenix, Ariz.	192	124	43	14	6	2	14
Pueblo, Colo.	37	27	10	—	—	—	4
Salt Lake City, Utah	117	84	21	8	1	3	10
Tucson, Ariz.	U	U	U	U	U	U	U
PACIFIC	1,836	1,289	371	114	33	29	217
Berkeley, Calif.	12	7	5	—	—	—	2
Fresno, Calif.	126	77	30	15	—	4	9
Glendale, Calif.	17	9	1	6	1	—	1
Honolulu, Hawaii	99	75	18	6	—	—	9
Long Beach, Calif.	62	45	9	6	2	—	7
Los Angeles, Calif.	331	228	69	21	9	4	44
Pasadena, Calif.	19	16	1	1	—	1	1
Portland, Oreg.	121	91	27	3	—	—	13
Sacramento, Calif.	190	133	40	13	3	1	24
San Diego, Calif.	186	121	45	11	5	4	18
San Francisco, Calif.	153	112	28	6	2	5	22
San Jose, Calif.	198	144	36	7	8	3	31
Santa Cruz, Calif.	42	34	6	1	—	1	9
Seattle, Wash.	114	70	26	12	3	3	10
Spokane, Wash.	55	42	11	1	—	1	6
Tacoma, Wash.	111	85	19	5	—	2	11
TOTAL	14,164[¶]	9,673	3,034	873	326	250	1,120

U: Unavailable. —: No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

[†] Pneumonia and influenza.

[§] Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

[¶] Total includes unknown ages.

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